



Rep. Jay Hoffman

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1 AMENDMENT TO SENATE BILL 904

2 AMENDMENT NO. _____. Amend Senate Bill 904 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The Workers' Compensation Act is amended by
5 changing Sections 8.2 and 8.2a as follows:

6 (820 ILCS 305/8.2)

7 Sec. 8.2. Fee schedule.

8 (a) Except as provided for in subsection (c), for
9 procedures, treatments, or services covered under this Act and
10 rendered or to be rendered on and after February 1, 2006, the
11 maximum allowable payment shall be 90% of the 80th percentile
12 of charges and fees as determined by the Commission utilizing
13 information provided by employers' and insurers' national
14 databases, with a minimum of 12,000,000 Illinois line item
15 charges and fees comprised of health care provider and hospital
16 charges and fees as of August 1, 2004 but not earlier than

1 August 1, 2002. These charges and fees are provider billed
2 amounts and shall not include discounted charges. The 80th
3 percentile is the point on an ordered data set from low to high
4 such that 80% of the cases are below or equal to that point and
5 at most 20% are above or equal to that point. The Commission
6 shall adjust these historical charges and fees as of August 1,
7 2004 by the Consumer Price Index-U for the period August 1,
8 2004 through September 30, 2005. The Commission shall establish
9 fee schedules for procedures, treatments, or services for
10 hospital inpatient, hospital outpatient, emergency room and
11 trauma, ambulatory surgical treatment centers, and
12 professional services. These charges and fees shall be
13 designated by geozip or any smaller geographic unit. The data
14 shall in no way identify or tend to identify any patient,
15 employer, or health care provider. As used in this Section,
16 "geozip" means a three-digit zip code based on data
17 similarities, geographical similarities, and frequencies. A
18 geozip does not cross state boundaries. As used in this
19 Section, "three-digit zip code" means a geographic area in
20 which all zip codes have the same first 3 digits. If a geozip
21 does not have the necessary number of charges and fees to
22 calculate a valid percentile for a specific procedure,
23 treatment, or service, the Commission may combine data from the
24 geozip with up to 4 other geozips that are demographically and
25 economically similar and exhibit similarities in data and
26 frequencies until the Commission reaches 9 charges or fees for

1 that specific procedure, treatment, or service. In cases where
2 the compiled data contains less than 9 charges or fees for a
3 procedure, treatment, or service, reimbursement shall occur at
4 76% of charges and fees as determined by the Commission in a
5 manner consistent with the provisions of this paragraph.
6 Providers of out-of-state procedures, treatments, services,
7 products, or supplies shall be reimbursed at the lesser of that
8 state's fee schedule amount or the fee schedule amount for the
9 region in which the employee resides. If no fee schedule exists
10 in that state, the provider shall be reimbursed at the lesser
11 of the actual charge or the fee schedule amount for the region
12 in which the employee resides. Not later than September 30 in
13 2006 and each year thereafter, the Commission shall
14 automatically increase or decrease the maximum allowable
15 payment for a procedure, treatment, or service established and
16 in effect on January 1 of that year by the percentage change in
17 the Consumer Price Index-U for the 12 month period ending
18 August 31 of that year. The increase or decrease shall become
19 effective on January 1 of the following year. As used in this
20 Section, "Consumer Price Index-U" means the index published by
21 the Bureau of Labor Statistics of the U.S. Department of Labor,
22 that measures the average change in prices of all goods and
23 services purchased by all urban consumers, U.S. city average,
24 all items, 1982-84=100.

25 (a-1) Notwithstanding the provisions of subsection (a) and
26 unless otherwise indicated, the following provisions shall

1 apply to the medical fee schedule starting on September 1,
2 2011:

3 (1) The Commission shall establish and maintain fee
4 schedules for procedures, treatments, products, services,
5 or supplies for hospital inpatient, hospital outpatient,
6 emergency room, ambulatory surgical treatment centers,
7 accredited ambulatory surgical treatment facilities,
8 prescriptions filled and dispensed outside of a licensed
9 pharmacy, dental services, and professional services. This
10 fee schedule shall be based on the fee schedule amounts
11 already established by the Commission pursuant to
12 subsection (a) of this Section. However, starting on
13 January 1, 2012, these fee schedule amounts shall be
14 grouped into geographic regions in the following manner:

15 (A) Four regions for non-hospital fee schedule
16 amounts shall be utilized:

17 (i) Cook County;

18 (ii) DuPage, Kane, Lake, and Will Counties;

19 (iii) Bond, Calhoun, Clinton, Jersey,
20 Macoupin, Madison, Monroe, Montgomery, Randolph,
21 St. Clair, and Washington Counties; and

22 (iv) All other counties of the State.

23 (B) Fourteen regions for hospital fee schedule
24 amounts shall be utilized:

25 (i) Cook, DuPage, Will, Kane, McHenry, DeKalb,
26 Kendall, and Grundy Counties;

1 (ii) Kankakee County;

2 (iii) Madison, St. Clair, Macoupin, Clinton,
3 Monroe, Jersey, Bond, and Calhoun Counties;

4 (iv) Winnebago and Boone Counties;

5 (v) Peoria, Tazewell, Woodford, Marshall, and
6 Stark Counties;

7 (vi) Champaign, Piatt, and Ford Counties;

8 (vii) Rock Island, Henry, and Mercer Counties;

9 (viii) Sangamon and Menard Counties;

10 (ix) McLean County;

11 (x) Lake County;

12 (xi) Macon County;

13 (xii) Vermilion County;

14 (xiii) Alexander County; and

15 (xiv) All other counties of the State.

16 (2) If a geozip, as defined in subsection (a) of this
17 Section, overlaps into one or more of the regions set forth
18 in this Section, then the Commission shall average or
19 repeat the charges and fees in a geozip in order to
20 designate charges and fees for each region.

21 (3) In cases where the compiled data contains less than
22 9 charges or fees for a procedure, treatment, product,
23 supply, or service or where the fee schedule amount cannot
24 be determined by the non-discounted charge data,
25 non-Medicare relative values and conversion factors
26 derived from established fee schedule amounts, coding

1 crosswalks, or other data as determined by the Commission,
2 reimbursement shall occur at 76% of charges and fees until
3 September 1, 2011 and 53.2% of charges and fees thereafter
4 as determined by the Commission in a manner consistent with
5 the provisions of this paragraph.

6 (4) To establish additional fee schedule amounts, the
7 Commission shall utilize provider non-discounted charge
8 data, non-Medicare relative values and conversion factors
9 derived from established fee schedule amounts, and coding
10 crosswalks. The Commission may establish additional fee
11 schedule amounts based on either the charge or cost of the
12 procedure, treatment, product, supply, or service.

13 (5) Implants shall be reimbursed at 25% above the net
14 manufacturer's invoice price less rebates, plus actual
15 reasonable and customary shipping charges whether or not
16 the implant charge is submitted by a provider in
17 conjunction with a bill for all other services associated
18 with the implant, submitted by a provider on a separate
19 claim form, submitted by a distributor, or submitted by the
20 manufacturer of the implant. "Implants" include the
21 following codes or any substantially similar updated code
22 as determined by the Commission: 0274
23 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens
24 implant); 0278 (implants); 0540 and 0545 (ambulance); 0624
25 (investigational devices); and 0636 (drugs requiring
26 detailed coding). Non-implantable devices or supplies

1 within these codes shall be reimbursed at 65% of actual
2 charge, which is the provider's normal rates under its
3 standard chargemaster. A standard chargemaster is the
4 provider's list of charges for procedures, treatments,
5 products, supplies, or services used to bill payers in a
6 consistent manner.

7 (6) The Commission shall automatically update all
8 codes and associated rules with the version of the codes
9 and rules valid on January 1 of that year.

10 (a-2) For procedures, treatments, services, or supplies
11 covered under this Act and rendered or to be rendered on or
12 after September 1, 2011, the maximum allowable payment shall be
13 70% of the fee schedule amounts, which shall be adjusted yearly
14 by the Consumer Price Index-U, as described in subsection (a)
15 of this Section.

16 (a-3) Prescriptions filled and dispensed outside of a
17 licensed pharmacy shall be subject to a fee schedule that shall
18 not exceed the Average Wholesale Price (AWP) plus a dispensing
19 fee of \$4.18. AWP or its equivalent as registered by the
20 National Drug Code shall be set forth for that drug on that
21 date as published in Medispan.

22 (b) Notwithstanding the provisions of subsection (a), if
23 the Commission finds that there is a significant limitation on
24 access to quality health care in either a specific field of
25 health care services or a specific geographic limitation on
26 access to health care, it may change the Consumer Price Index-U

1 increase or decrease for that specific field or specific
2 geographic limitation on access to health care to address that
3 limitation.

4 (c) The Commission shall establish by rule a process to
5 review those medical cases or outliers that involve
6 extra-ordinary treatment to determine whether to make an
7 additional adjustment to the maximum payment within a fee
8 schedule for a procedure, treatment, or service.

9 (d) When a patient notifies a provider that the treatment,
10 procedure, or service being sought is for a work-related
11 illness or injury and furnishes the provider the name and
12 address of the responsible employer, the provider shall bill
13 the employer or its designee directly. The employer or its
14 designee shall make payment for treatment directly to the
15 provider in accordance with the provisions of this Section.
16 Providers and providers shall submit bills and records in
17 accordance with the provisions of this Section.

18 (1) All payments to providers for treatment provided
19 pursuant to this Act shall be made within 30 days of
20 receipt of the bills as long as the bill claim contains
21 substantially all the required data elements necessary to
22 adjudicate the bill bills.

23 (2) If the bill claim does not contain substantially
24 all the required data elements necessary to adjudicate the
25 bill, or the claim is denied for any other reason, in whole
26 or in part, the employer or insurer shall provide written

1 notification to the provider in the form of an explanation
2 of benefits, explaining the basis for the denial and
3 describing any additional necessary data elements, ~~to the~~
4 ~~provider~~ within 30 days of receipt of the bill. The
5 Commission, with assistance from the Medical Fee Advisory
6 Board, shall adopt rules detailing the requirements for the
7 explanation of benefits required under this subsection.

8 (3) In the case (i) of nonpayment to a provider within
9 30 days of receipt of the bill which contained
10 substantially all of the required data elements necessary
11 to adjudicate the bill, (ii) of ~~or~~ nonpayment to a provider
12 of a portion of such a bill, or (iii) where the provider
13 has not been issued an explanation of benefits for a bill
14 up to the lesser of the actual charge or the payment level
15 set by the Commission in the fee schedule established in
16 this Section, the bill, or portion of the bill up to the
17 lesser of the actual charge or the payment level set by the
18 Commission in the fee scheduled established in this
19 Section, shall incur interest at a rate of 2% ~~1%~~ per month
20 payable by the employer to the provider. Any required
21 interest payments shall be made by the employer or its
22 insurer to the provider not later than ~~within~~ 30 days after
23 payment of the bill.

24 (4) If the employer or its insurer fails to pay
25 interest required pursuant to this subsection (d), the
26 provider may bring an action in circuit court to enforce

1 the provisions of this subsection (d) against the employer
2 or its insurer responsible for insuring the employer's
3 liability pursuant to item (3) of subsection (a) of Section
4 4. Interest under this subsection (d) is only payable to
5 the provider. An employee is not responsible for the
6 payment of interest under this Section. The right to
7 interest under this subsection (d) shall not delay,
8 diminish, restrict, or alter in any way the benefits to
9 which the employee or his or her dependents are entitled
10 under this Act.

11 (e) Except as provided in subsections (e-5), (e-10), and
12 (e-15), a provider shall not hold an employee liable for costs
13 related to a non-disputed procedure, treatment, or service
14 rendered in connection with a compensable injury. The
15 provisions of subsections (e-5), (e-10), (e-15), and (e-20)
16 shall not apply if an employee provides information to the
17 provider regarding participation in a group health plan. If the
18 employee participates in a group health plan, the provider may
19 submit a claim for services to the group health plan. If the
20 claim for service is covered by the group health plan, the
21 employee's responsibility shall be limited to applicable
22 deductibles, co-payments, or co-insurance. Except as provided
23 under subsections (e-5), (e-10), (e-15), and (e-20), a provider
24 shall not bill or otherwise attempt to recover from the
25 employee the difference between the provider's charge and the
26 amount paid by the employer or the insurer on a compensable

1 injury, or for medical services or treatment determined by the
2 Commission to be excessive or unnecessary.

3 (e-5) If an employer notifies a provider that the employer
4 does not consider the illness or injury to be compensable under
5 this Act, the provider may seek payment of the provider's
6 actual charges from the employee for any procedure, treatment,
7 or service rendered. Once an employee informs the provider that
8 there is an application filed with the Commission to resolve a
9 dispute over payment of such charges, the provider shall cease
10 any and all efforts to collect payment for the services that
11 are the subject of the dispute. Any statute of limitations or
12 statute of repose applicable to the provider's efforts to
13 collect payment from the employee shall be tolled from the date
14 that the employee files the application with the Commission
15 until the date that the provider is permitted to resume
16 collection efforts under the provisions of this Section.

17 (e-10) If an employer notifies a provider that the employer
18 will pay only a portion of a bill for any procedure, treatment,
19 or service rendered in connection with a compensable illness or
20 disease, the provider may seek payment from the employee for
21 the remainder of the amount of the bill up to the lesser of the
22 actual charge, negotiated rate, if applicable, or the payment
23 level set by the Commission in the fee schedule established in
24 this Section. Once an employee informs the provider that there
25 is an application filed with the Commission to resolve a
26 dispute over payment of such charges, the provider shall cease

1 any and all efforts to collect payment for the services that
2 are the subject of the dispute. Any statute of limitations or
3 statute of repose applicable to the provider's efforts to
4 collect payment from the employee shall be tolled from the date
5 that the employee files the application with the Commission
6 until the date that the provider is permitted to resume
7 collection efforts under the provisions of this Section.

8 (e-15) When there is a dispute over the compensability of
9 or amount of payment for a procedure, treatment, or service,
10 and a case is pending or proceeding before an Arbitrator or the
11 Commission, the provider may mail the employee reminders that
12 the employee will be responsible for payment of any procedure,
13 treatment or service rendered by the provider. The reminders
14 must state that they are not bills, to the extent practicable
15 include itemized information, and state that the employee need
16 not pay until such time as the provider is permitted to resume
17 collection efforts under this Section. The reminders shall not
18 be provided to any credit rating agency. The reminders may
19 request that the employee furnish the provider with information
20 about the proceeding under this Act, such as the file number,
21 names of parties, and status of the case. If an employee fails
22 to respond to such request for information or fails to furnish
23 the information requested within 90 days of the date of the
24 reminder, the provider is entitled to resume any and all
25 efforts to collect payment from the employee for the services
26 rendered to the employee and the employee shall be responsible

1 for payment of any outstanding bills for a procedure,
2 treatment, or service rendered by a provider.

3 (e-20) Upon a final award or judgment by an Arbitrator or
4 the Commission, or a settlement agreed to by the employer and
5 the employee, a provider may resume any and all efforts to
6 collect payment from the employee for the services rendered to
7 the employee and the employee shall be responsible for payment
8 of any outstanding bills for a procedure, treatment, or service
9 rendered by a provider as well as the interest awarded under
10 subsection (d) of this Section. In the case of a procedure,
11 treatment, or service deemed compensable, the provider shall
12 not require a payment rate, excluding the interest provisions
13 under subsection (d), greater than the lesser of the actual
14 charge or the payment level set by the Commission in the fee
15 schedule established in this Section. Payment for services
16 deemed not covered or not compensable under this Act is the
17 responsibility of the employee unless a provider and employee
18 have agreed otherwise in writing. Services not covered or not
19 compensable under this Act are not subject to the fee schedule
20 in this Section.

21 (f) Nothing in this Act shall prohibit an employer or
22 insurer from contracting with a health care provider or group
23 of health care providers for reimbursement levels for benefits
24 under this Act different from those provided in this Section.

25 (g) On or before January 1, 2010 the Commission shall
26 provide to the Governor and General Assembly a report regarding

1 the implementation of the medical fee schedule and the index
2 used for annual adjustment to that schedule as described in
3 this Section.

4 (Source: P.A. 97-18, eff. 6-28-11.)

5 (820 ILCS 305/8.2a)

6 Sec. 8.2a. Electronic claims.

7 (a) The Director of Insurance shall adopt rules to do all
8 of the following:

9 (1) Ensure that all health care providers and
10 facilities submit medical bills for payment on
11 standardized forms.

12 (2) Require acceptance by employers and insurers of
13 electronic claims for payment of medical services.

14 (3) Ensure confidentiality of medical information
15 submitted on electronic claims for payment of medical
16 services.

17 (4) Ensure that health care providers have an
18 opportunity to comply with requests for records by
19 employers and insurers for the authorization of the payment
20 of workers' compensation claims.

21 (5) Ensure that health care providers are responsible
22 for supplying only those medical records pertaining to the
23 provider's own claims that are minimally necessary under
24 the federal Health Insurance Portability and
25 Accountability Act of 1996.

1 (6) Provide that any electronically submitted bill
2 determined to be complete but not paid or objected to
3 within 30 days shall be subject to interest pursuant to
4 item (3) of subsection (d) of Section 8.2.

5 (7) Provide that the Department of Insurance shall
6 impose an administrative fine if it determines that an
7 employer or insurer has failed to comply with the
8 electronic claims acceptance and response process. The
9 amount of the administrative fine shall be no greater than
10 \$1,000 per each violation, but shall not exceed \$10,000 for
11 identical violations during a calendar year.

12 (b) To the extent feasible, standards adopted pursuant to
13 subdivision (a) shall be consistent with existing standards
14 under the federal Health Insurance Portability and
15 Accountability Act of 1996 and standards adopted under the
16 Illinois Health Information Exchange and Technology Act.

17 (c) The rules requiring employers and insurers to accept
18 electronic claims for payment of medical services shall be
19 proposed on or before January 1, 2012, and shall require all
20 employers and insurers to accept electronic claims for payment
21 of medical services on or before June 30, 2012. The Director of
22 Insurance shall adopt rules by September 1, 2018 to implement
23 the changes to this Section made by this amendatory Act of this
24 100th General Assembly. The Commission, with assistance from
25 the Department and the Medical Fee Advisory Board, shall
26 publish on it its Internet website a companion guide to assist

1 with compliance with electronic claims rules. The Medical Fee
2 Advisory Board shall periodically review the companion guide.

3 (d) The Director of Insurance shall by rule establish
4 criteria for granting exceptions to employers, insurance
5 carriers, and health care providers who are unable to submit or
6 accept medical bills electronically.

7 (Source: P.A. 97-18, eff. 6-28-11.)

8 Section 99. Effective date. This Act takes effect upon
9 becoming law.".